

<i>SERFF Tracking Number:</i>	<i>LBLI-125599290</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Liberty Bankers Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>38647</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>L07I Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L07I.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>New Life Riders & Application</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Filing at a Glance

Company: Liberty Bankers Life Insurance Company

Product Name: New Life Riders & Application	SERFF Tr Num: LBLI-125599290	State: ArkansasLH
TOI: L07I Individual Life - Whole	SERFF Status: Closed	State Tr Num: 38647
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Author: Chad Leiding	Disposition Date: 04/18/2008
	Date Submitted: 04/08/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 04/18/2008	
State Status Changed: 04/18/2008	Deemer Date:
Corresponding Filing Tracking Number:	
Filing Description:	
Life Riders	
LBL-WPR-0408	
LBL-CHILD-0408	
LBL-ADD-0408	

Policy Application

SERFF Tracking Number: LBLI-125599290 State: Arkansas
Filing Company: Liberty Bankers Life Insurance Company State Tracking Number: 38647
Company Tracking Number:
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: New Life Riders & Application
Project Name/Number: /
LBL-SIM-APP-0408

The above listed forms are submitted for your review and approval. These forms are new and are not intended to replace any previously approved forms.

Riders

LBL-WPR-0408 is a standard waiver of premium rider where if total disability occurs before the insured's 60th birthday, premiums will be waived while the insured is disabled. The premiums for this rider are listed in the table on the reverse of the rider.

LBL-CHILD-0408 is a standard convertible level term insurance children's rider. Benefits are payable to age 25. Before the child reaches age 25, the policy may be converted to a permanent life insurance policy without proof of insurability. The Annual premium is \$39.00, the monthly premium is \$3.49.

LBL-ADD-0408 is a standard accidental death and dismemberment rider with common carrier benefit. The premium is a flat \$1.00 per thousand per year expiring at age 75.

Life riders LBL-WPR-0408, LBL-CHILD-0408, LBL-ADD-0408 will be used with previously approved policy forms LBL-WL-POL-0407, LBL Term20-0607 and LBL Term20-RPU-0607.

Policy Application

LBL-SIM-APP-0408 is a new policy application that will be used with previously approved policy forms LBL-MWL-0806 and LBL-WL-POL-0407.

To the best of our knowledge, this filing is complete and is intended to comply with the insurance laws of your jurisdiction.

Company and Contact

Filing Contact Information

Chad Leiding, V.P Compliance

chad.leiding@libertybankerslife.com

SERFF Tracking Number: LBLI-125599290 State: Arkansas
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Product Name: New Life Riders & Application
Project Name/Number: /

1800 Valley View Lane (469) 522-4332 [Phone]
Dallas, TX 75234 (469) 522-4380[FAX]

Filing Company Information

Liberty Bankers Life Insurance Company CoCode: 68543 State of Domicile: Oklahoma
1800 Valley View Lane Group Code: 3436 Company Type: LAH
Suite 300
Dallas, TX 75234 Group Name: State ID Number:
(469) 522-4332 ext. [Phone] FEIN Number: 25-1093227

<i>SERFF Tracking Number:</i>	<i>LBLI-125599290</i>	<i>State:</i>	<i>Arkansas</i>
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<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
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Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	Yes
Fee Explanation:	\$25/form
Per Company:	No

SERFF Tracking Number:	LBLI-125599290	State:	Arkansas
Filing Company:	Liberty Bankers Life Insurance Company	State Tracking Number:	38647
Company Tracking Number:			
TOI:	L071 Individual Life - Whole	Sub-TOI:	L071.101 Fixed/Indeterminate Premium - Single Life
Product Name:	New Life Riders & Application		
Project Name/Number:	/		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	04/18/2008	04/18/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
LBL-CHILD-0408	Form	Chad Leiding	04/17/2008	04/17/2008
LBL-APP-IWL-0408	Form	Chad Leiding	04/11/2008	04/11/2008
Readability Certification	Supporting Document	Chad Leiding	04/08/2008	04/08/2008

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<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>New Life Riders & Application</i>		
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Disposition

Disposition Date: 04/18/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: LBLI-125599290 State: Arkansas

Filing Company: Liberty Bankers Life Insurance Company State Tracking Number: 38647

Company Tracking Number:

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: New Life Riders & Application

Project Name/Number: /

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document	Readability Certification		Yes
Form	LBL-WPR-0408		Yes
Form (revised)	LBL-CHILD-0408		Yes
Form	LBL-CHILD-0408		Yes
Form	LBL-ADD-0408		Yes
Form (revised)	LBL-APP-IWL-0408		Yes
Form	LBL-APP-IWL-0408		Yes

SERFF Tracking Number: LBLI-125599290 State: Arkansas

Filing Company: Liberty Bankers Life Insurance Company State Tracking Number: 38647

Company Tracking Number:

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: New Life Riders & Application

Project Name/Number: /

Amendment Letter

Amendment Date:

Submitted Date: 04/17/2008

Comments:

We are further revising this submission for form LBL-CHILD-0408. We inadvertently left out a termination provision. It has now been added and the revised form is attached.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
LBL-CHILD-0408	Certificate Amendment, 0408 Insert Page, Endorsement or Rider	LBL-CHILD- Initial					61	LBL-CHILD-0408 - Child Rider - Generic.pdf

SERFF Tracking Number: LBLI-125599290 State: Arkansas

Filing Company: Liberty Bankers Life Insurance Company State Tracking Number: 38647

Company Tracking Number:

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: New Life Riders & Application

Project Name/Number: /

Amendment Letter

Amendment Date:

Submitted Date: 04/11/2008

Comments:

We are replacing the filed version of the application (Form #LBL-SIM-APP-0408) with this version. It will have the same form #. Sorry for the inconvenience.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
LBL-APP-IWL-0408	Application/ELBL-APP-nrollment Form	IWL-0408	Initial				45	LBL-SIM-APP-0408-Generic.pdf

SERFF Tracking Number: LBLI-125599290 State: Arkansas
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Company Tracking Number:
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: New Life Riders & Application
Project Name/Number: /

Amendment Letter

Amendment Date:
Submitted Date: 04/08/2008

Comments:

Also attached is the Flesch Readability Certification.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Readability Certification

Comment:
Readability Certification.pdf

SERFF Tracking Number: LBLI-125599290 State: Arkansas

Filing Company: Liberty Bankers Life Insurance Company State Tracking Number: 38647

Company Tracking Number:

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: New Life Riders & Application

Project Name/Number: /

Form Schedule

Lead Form Number: LBL-WPR-0408

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LBL-WPR-0408	Certificate Amendment, Insert Page, Endorsement or Rider	LBL-WPR-0408	Initial		39	LBL-WPR-0408 - Waiver of Premium Rider - Generic.pdf
	LBL-CHILD-0408	Certificate Amendment, Insert Page, Endorsement or Rider	LBL-CHILD-0408	Initial		61	LBL-CHILD-0408 - Child Rider - Generic.pdf
	LBL-ADD-0408	Certificate Amendment, Insert Page, Endorsement or Rider	LBL-ADD-0408	Initial		53	LBL-ADD-0408 - Accidental Death & Dismemberment Rider - Generic.pdf
	LBL-APP-IWL-0408	Application/Enrollment Form	LBL-APP-IWL-0408	Initial		45	LBL-SIM-APP-0408- Generic.pdf

WAIVER OF PREMIUM RIDER

BENEFIT After approval of a claim for Total Disability which occurred before age sixty, the Company will waive all premiums for this Policy that become due while Total Disability continues.

AGE "Age Sixty" when used in this Rider, means the policy anniversary on or immediately following the Insured's sixtieth birthday.

TOTAL DISABILITY

1. **DEFINITION** Total Disability means that the Insured is completely and continuously unable to engage for remuneration or profit in any occupation for which the Insured is, or could reasonably become, qualified by reason of education, training or experience.
2. **REQUIREMENTS** Total Disability of the Insured requires:
 - a. the regular attendance by a licensed physician other than the Insured;
 - b. that Total Disability be caused by accidental bodily injury occurring, or disease first manifesting itself, after the Effective Date of this Rider, but before the insured's sixtieth birthday;
 - c. that disability has continued for six consecutive months; and
 - d. that this Rider and this Policy were in force when disability began. This Rider is not in force if any premium for this Policy or this Rider is in default.

NOTICE AND PROOF OF CLAIM Written notice of a claim and due proof of Total Disability must be given to the Company at its Home Office:

1. during the lifetime of the Insured; and
2. within one year after the beginning of disability.

Failure to give notice and proof within one year will not invalidate a claim if it is shown that the notice and proof were given as soon as was reasonably possible; however, no premium due more than one year prior to proof of claim will be waived.

Prior to the approval of any claim, the Company will have the right and opportunity to have one or more physicians designated to examine the Insured as often as the Company may reasonably require.

Premiums becoming due before the Company approves a Total Disability claim should be paid prior to the expiration of the Grace Period. If the claim is approved, any premium paid which is eligible for waiver will be refunded.

PROOF OF CONTINUANCE After approval of a Total Disability claim, the Company may require due proof of the continuance of Total Disability and may require the Insured to be examined at reasonable intervals by one or more physicians designated by the Company. The Company will not require proof or examination more often than once a year after Total Disability has continued for two full years. If proof is not furnished on request or if the Insured fails to submit to examination, the premiums falling due thereafter will not be waived.

NOTICE OF RECOVERY The Owner shall give immediate notice to the Company when the Insured recovers from Total Disability.

LIMITATIONS No benefit will be provided by this Rider if disability results from an intentionally self-inflicted injury or from an act attributable to war, whether declared or undeclared, while the Insured is in the military service of any country.

GENERAL PROVISIONS

1. This Rider is made a part of this Policy to which it is attached.
2. This benefit is subject to all the provisions of this Rider and this Policy.
3. The Effective Date of this Rider is the Date of Issue of this Policy unless otherwise shown on the Policy Data Schedule of this Policy.
4. The premium for this Rider is shown on the Policy Data Schedule of this Policy.
5. The amount payable under any settlement will not be reduced by any premiums waived under this Rider. Any surrender values will be the same as if the premium waived had been paid in cash.

TERMINATION OF RIDER

This Rider terminates:

1. when any premium for this Rider or this Policy is in default beyond the end of its Grace Period; or
2. on the due date of any premium on this Policy by written request of the Owner; or
3. at age sixty of the Insured; but an eligible claim for disability occurring before age sixty is not affected.

WAIVER OF PREMIUM

Rate factors

BENEFIT After approval of a claim for Total Disability which occurred before age sixty, the Company will waive all premiums for this Policy that become due while Total Disability continues.

Rates as a % of Gross Premiums—Inclusive of Policy Fee

Issue Ages	Male	Female
20	4%	5%
21	4%	5%
22	4%	5%
23	4%	5%
24	5%	6%
25	5%	6%
26	5%	6%
27	5%	6%
28	5%	6%
29	5%	6%
30	5%	6%
31	5%	6%
32	5%	6%
33	5%	7%
34	6%	7%
35	6%	7%
36	6%	7%
37	6%	7%
38	6%	8%
39	6%	8%
40	7%	8%
41	7%	8%
42	7%	9%
43	7%	9%
44	8%	9%
45	8%	10%
46	8%	10%
47	9%	10%
48	9%	11%
49	10%	12%
50	11%	13%
51	11%	14%
52	12%	14%
53	13%	15%
54	14%	16%
55	15%	17%

CHILDREN'S BENEFIT RIDER
(Level Term Insurance to Age 25, Convertible)
\$5,000 Per Unit
_____ Unit (s)

The Effective Date of this Agreement is the Date of Policy if attached when the Policy was issued. The number of units insured is shown on the Schedule Page. If added later, the Effective Date and number of units of this Agreement are shown above.

The consideration for this Agreement is the application and payment of the Initial Premium. A like sum is payable on each Due Date until this Agreement ends.

We will pay the Sum Insured (units in force) to your Child's Beneficiary immediately after these conditions are met:

1. We receive due proof of the death of an Insured Child.
2. Death occurs while this Agreement is in force for that Child.

SUM INSURED

For each unit of this Agreement:

The Sum Insured on each Insured Child is \$5,000.

DEFINITIONS

Wherever used in this Agreement:

"Insured Child" – means each child of yours (including each stepchild and legally adopted child) who, unless excluded in this Agreement:

1. Is named on the application for this Agreement and has not reached the 18th birthday on the Agreement Effective Date; or
2. Is born to you after the Agreement Effective Date.

Any child you legally adopt after the Agreement Effective Date may be insured by this Agreement without additional charge, after written request to us and subject to our approval. No child will be insured until 15 days old. In no case will the insurance on an Insured Child continue after the next Policy anniversary following the child's 25th birthday.

"Child's Beneficiary" – means you, if living, otherwise your Spouse, if living, otherwise the estate of the deceased Insured Child. You can change this. (See the "Beneficiary" provision of the attached Policy).

"Owner" – (a) During your lifetime, it means the Owner of the Policy; (b) After your death and if your Spouse survives, it means your Spouse; (c) After the death of you both, it means any surviving Insured Child, but only with respect to the term insurance on his or her life.

PAID UP INSURANCE

In the event of your death while the policy and this rider are in force, any insurance then provided by this rider shall become paid-up term insurance expiring on the life of each insured child on the same date it would have expired had you not died.

CONVERSION PRIVILEGE

1. While this Agreement is in force, the insurance on any Insured Child may be exchanged for a permanent life plan in the same amount. No proof of insurability is needed.
2. At the following special times, the new policy amount may be up to five (5) times the Sum Insured in this Agreement:
 - (a) For conversion effective within 31 days after the next Policy Anniversary following the Insured Child's 25th birthday; or
 - (b) Upon written application to us within 31 days after the date of marriage if prior to the Insured Child's 25th birthday.
3. The new policy will be dated with the date of exchange. If so:
 - (a) The new premiums will be based on the classification used in this Agreement for the Child's attained age. The premium will be at the rates then in use by us.
 - (b) Any extra benefits may be added to the new policy only with our consent.
4. If this Agreement is in force on a paid-up basis due to your death, the insurance on any person then insured may be converted to any permanent life plan. The new policy amount may not be more than the amount of paid-up insurance. The request must be written and include surrender of that person's paid-up insurance. Premiums will be charged on the new permanent life plan.

TERMINATION

This rider automatically terminates on the occurrence of the earliest of the following:

1. On the Policy anniversary on or following the Insured's 25th birthday; or
2. Any premium remains unpaid beyond the grace period; or
3. Your written request received by Us at Our Home Office.

When coverage is scheduled to terminate on a given date, it will terminate at 12:00 midnight at the end of that day. We will return to You any premium payment for this rider received by Us past the termination date

ACCIDENTAL DEATH AND DISMEMBERMENT WITH COMMON CARRIER BENEFIT RIDER

BENEFITS

Liberty Bankers Life Insurance Company agrees to pay the sum specified per the table below, in accordance with the terms of the policy and this rider. The AD&D Sum Insured is shown on the Schedule Page of the policy. The amount payable on this rider will be included in the proceeds of the policy. The proceeds will be paid to the beneficiary upon receipt, at the Company's Home Office, of due proof that the death of the Insured:

- A) was directly caused by an accidental bodily injury, independent of all causes, which is supported by an autopsy (except in the case of drowning or of internal injuries revealed by an autopsy, or smoke inhalation due to fire); and
- B) such injury and the Insured's death occurred while the policy and this rider were in force; and
- C) was not intentionally self-inflicted; and
- D) occurred within 90 days from the date of such injury and prior to the termination of this rider .

If within 90 days following an accident causing an Injury (as defined in this rider), the Insured incurs a loss as specified below, We will pay the sum specified for such loss. We will pay for one loss, the largest loss, if more than one loss is incurred.

LOSS	SUM SPECIFIED
Life	AD&D Sum Insured
Both Hands	AD&D Sum Insured
Both Feet	AD&D Sum Insured
Sight of Both Eyes	AD&D Sum Insured
One Hand and One Foot	AD&D Sum Insured
Sight of One Eye and either One Hand or One Foot	AD&D Sum Insured
One Hand or One Foot or Sight of One Eye	One-half the AD&D Sum Insured

Loss of a foot means complete severance at or above the ankle joint. Loss of sight means entire and irrecoverable loss of sight. Loss of a hand means the entire loss of five fingers.

We will pay an additional benefit if a covered injury the Insured sustains while riding as a fare-paying passenger on a Common Carrier results in the Insured's death within 90 days from the date of such injury. The additional benefit will be equal to the AD&D Sum Insured specified on the Schedule Page.

GENERAL EXCLUSIONS

The Accidental Death Benefit provided by this rider shall not be payable if:

The Insured consumes alcohol in such amounts as to cause his/her death, directly or indirectly,

OR

His/her death is contributed to, wholly or in part, by any of the following causes:

- A) committing, or attempting to commit, suicide or self-destruction, while sane or insane; or
- B) intentional self-inflicted injuries, while sane or insane; or
- C) physical or mental disease or infirmity of any kind; or
- D) medical or surgical treatment of a disease or illness; or
- E) travel or flight on, or descent from, any kind of aircraft if the Insured:
 - 1) has any duties aboard such aircraft; or
 - 2) is receiving any kind of training or instructions; or
 - 3) the aircraft is operated by or for any military force; or

(exclusions continued next page)

- F) hang gliding or skydiving; or
- G) injuries sustained as the result of war, declared or undeclared, or insurrection, or service in the armed forces or auxiliary units; or
- H) voluntary participation in a riot, strike, or civil disobedience; or
- I) committing, or attempting to commit, or participating in a crime, assault, felony or any other illegal act; or
- J) taking of any drug, medication, or sedative unless taken as prescribed by a physician, including any combination with alcohol; or
- K) being under the influence, as described in the laws of the place where the accident occurs, of alcohol, drug or controlled substance; or
- L) taking any kind of poison, or the inhaling of any kind of gas voluntarily.

GENERAL PROVISIONS AND DEFINITIONS

BENEFICIARY: The person, persons, or entity named in writing as shown on the Schedule Page to receive the benefit at the Insured's death.

COMMON CARRIER: Commercial airline, bus, railway, boat or ship, subway or streetcar operating as a regularly scheduled passenger carrier.

EFFECTIVE DATE: The effective date of this rider is the date of issue of the policy unless otherwise specified on the policy schedule page of the policy.

EXAMINATION/AUTOPSY: We reserve the right, before paying any benefits, to have a physician of Our choice conduct an examination, or autopsy if applicable, of the Insured, at Our expense, unless forbidden by law.

INJURY: Bodily injury directly caused by an accident, independent of all other causes, which is suffered by the Insured.

POLICY: This rider is made a part of the policy to which it is attached and is subject to all the provisions of the policy and this rider.

PREMIUM: The premium for this rider is shown on the Schedule Page of the policy.

AD&D SUM INSURED: The amount payable upon the injury or death of the Insured if this policy is then in force. It is shown on the Schedule Page of the policy.

TERMINATION

This rider automatically terminates on the occurrence of the earliest of the following:

- A) On the rider anniversary on or following the Insured's 75th birthday; or
- B) Any premium remains unpaid beyond the grace period; or
- C) Your written request received by Us at Our Home Office; or
- D) Benefit payment has been made as per payment of benefits clause.

When coverage is scheduled to terminate on a given date, it will terminate at 12:00 midnight at the end of that day. We will return to You any premium payment received by Us after the rider termination.



Liberty Bankers Life

Insurance Company

Application for
"Simplified Issue Market"
Use with SIMPL/MWL

P.O. Box 341989 Austin, Texas 78734 1-800-604-8002 FAX 512-263-6981 E-Mail: lblicnb@tslic.com

All information must be provided to avoid delays. All questions are important, please read and complete each question.

Proposed Insured (First Name, Initial, Last Name)

State of Birth _____ Country of Birth _____

Date of Birth _____ Present Age _____

Sex _____ Height _____ Weight _____

Social Security No. _____

Street Address _____

City, State, Zip _____

Home/Cell Phone _____

Work Phone: _____

E-Mail Address _____

Occupation _____

1. Have you used tobacco in any form in the past 12 months?..... ☐ YES ☐ NO
2. Are you a U.S. Citizen, including resident alien? ☐ YES ☐ NO
If No, please explain type of visa or work permit: _____

OWNER of Policy (if other than Proposed Insured)

Relationship _____

Social Security No. _____

Street Address _____

City, State, Zip _____

Home/Cell Phone _____

Plan Applied For: ☐ SIMPL ☐ MWL

☐ OTHER _____

Classification: ☐ Tobacco ☐ Non-Tobacco

Face Amount \$ _____

Premium Amount \$ _____

Amount paid with application \$ _____

Premium Mode:

☐ Monthly Bank Draft

Draft Day: _____

☐ Check here to draft first premium

☐ Monthly List Bill

☐ Bi-Weekly

☐ Payroll Deduction

☐ Quarterly

☐ Semi-Annual

☐ Annual

Primary

Beneficiary _____

Relationship _____

Street Address _____

Home/Cell Phone _____

E-Mail _____

Contingent

Beneficiary _____

Relationship _____

Street Address _____

Home/Cell Phone _____

E-Mail _____

1. Does proposed Insured have existing life insurance policies or annuity contracts?..... ☐ YES ☐ NO
 2. Will this insurance replace or change any other insurance policies or annuity contracts? ☐ YES ☐ NO
- If "YES" to either question, please provide details of the insurance, including Amount, Company & Plan of Insurance and appropriate Replacement Form, if required: _____

Please read each question carefully and answer truthfully before signing application.

If the applicant answers YES to any question in Part 1, DO NOT PROCEED with the application.

Part 1

	YES	NO
To the best of your knowledge and belief, have you:		
1. Ever been diagnosed with congestive heart failure, cystic fibrosis, Alzheimer's, senile dementia, dementia, Down's Syndrome, terminal illness, muscular dystrophy, Huntington's Disease, amyotrophic lateral sclerosis (ALS), or had an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ever been diagnosed or received treatment for AIDS (Acquired Immune Deficiency Syndrome), AIDS Related Complex or tested positive for HIV Virus, or any other disorder of the immune system?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently or within the last 90 days:		
3. Been unable to care for yourself, bedridden at home, confined in a hospital, nursing home, hospice, assisted living or long-term care facility, or using oxygen?	<input type="checkbox"/>	<input type="checkbox"/>
4. Had undiagnosed chest pain, fainting, paralysis, coughed up or vomited blood?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you currently have uncontrolled high blood pressure or uncontrolled diabetes, diabetic coma, insulin shock, or diagnosis of diabetes at age 9 or younger, or diabetes associated with retinopathy, nephropathy, neuropathy or amputation?	<input type="checkbox"/>	<input type="checkbox"/>

If the applicant answers YES to 1 or more questions in Part 2, he/she will be considered for the MWL Plan only.

Part 2

	YES	NO
To the best of your knowledge and belief, within the last 2 years have you 1) had, 2) been diagnosed for, 3) had or have any new symptoms for, or 4) awaiting surgery, medical tests or test results for:		
1. Heart attack, irregular heartbeat, aneurysm, any condition leading to angioplasty or bypass surgery, cardiomyopathy, cardiac defibrillator, heart valve surgery, stroke, cerebrovascular insufficiency or blockage?	<input type="checkbox"/>	<input type="checkbox"/>
2. Internal cancer, melanoma, leukemia, sickle cell anemia, renal insufficiency or failure, hepatitis C, kidney disease (excluding passed kidney stones), liver disease including cirrhosis; chronic pancreatitis, Hodgkin's Disease, lymphoma, chronic lung disease including emphysema?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Paralysis, Parkinson's, Grand Mal epilepsy, multiple sclerosis, lupus or connective tissue disorder, organic brain disorder or suffer from mental retardation?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Schizophrenia, psychosis or suicidal thoughts or attempts, including hospitalization for major depression?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Alcoholism, drug abuse, narcotic addiction, or been convicted of felony?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you currently using a wheelchair or walker on a permanent basis?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Within the last one year, have you had an application for life insurance declined or refused for any reason?	<input type="checkbox"/>	<input type="checkbox"/>

Give Details to Questions Answered "YES" above: (Attach additional sheet, if necessary with applicant's signature) _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Any insurance must first be approved for issuance by Liberty Bankers Life Insurance Company on the basis of this application. Coverage will begin when the policy has been issued, received and accepted by the proposed insured or applicant with the first full premium paid to Liberty Bankers Life Insurance Company, while the proposed insured's health and other conditions remain as described in this application. Liberty Bankers Life Insurance Company is authorized to correct errors and omissions as necessary and acceptance of any policy issued on this application shall constitute ratification thereof, except that any amendment as to amount, classification, plan of insurance or benefits shall be made only with the written consent of the proposed insured or the applicant.

I authorize any physician, medical practitioner, hospital, clinic, other medical medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or employer to give the Company or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself. This authorization also includes information about drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company to release any information obtained only to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. I further acknowledge that I may revoke this authorization at any time by submitting a written request to the Company. As to this Authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for 24 months from the date shown below. I know that I or my representative may request a copy of this authorization.

I certify that I have reviewed the questions and responses contained on this application and that my responses to these questions have been accurately recorded. I understand that no agent is authorized to advise me that any inaccurate answer is acceptable.

X _____
Signature of Proposed Insured Date City/State

X _____
Signature of Applicant/Owner (if other than Proposed Insured) Date City/ State

Agent Statement:

	YES	NO
1. Did you give the applicant a copy of the Privacy Notice and other disclosure information?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you related to the Proposed Insured?	<input type="checkbox"/>	<input type="checkbox"/>
3. Was this application taken in person?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you know anything not disclosed which might affect the underwriting of this risk?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the Proposed Insured have any existing life insurance policies or annuity contracts?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is replacement of existing insurance involved in this application? If yes: Have you submitted	<input type="checkbox"/>	<input type="checkbox"/>
the appropriate replacement forms?	<input type="checkbox"/>	<input type="checkbox"/>

X _____
Printed Agent's Name Agent's Signature Agent's Number

LBL-SIM-APP-0408

CONDITIONAL RECEIPT – (Cross through if payment is NOT received).

NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO DELIVERY, UNLESS THE FOLLOWING CONDITIONS HAVE BEEN FULFILLED EXACTLY:

INSURANCE ISSUED BASED ON THE APPLICATION WILL TAKE EFFECT ONLY IF THESE CONDITIONS ARE MET:

1. That on the effective date the Proposed Insured is insurable as a standard risk under the Company's rules for the plan amount and premium rate applied for.
2. That the sum paid is equal to the FULL FIRST PREMIUM for the policy applied for.

INSURANCE ISSUED BASED ON THE APPLICATION WILL TAKE EFFECT ON THE LATEST OF:

- (a) date of the application; or (b) date requested in the application; or
- (c) date of the last of any medical examinations or tests required under the rules and practices of the Company.

The total amount of insurance which may become effective prior to delivery of the policy to the Owner shall not exceed \$25,000. This amount includes LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS then IN FORCE or APPLIED FOR with this Company.

LIBERTY BANKERS LIFE INSURANCE COMPANY has received \$ _____ for Applicant _____

By _____
Agent Date

**THE PREMIUM CHECK MUST BE MADE PAYABLE TO LIBERTY BANKERS LIFE INSURANCE COMPANY.
DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

This authorization complies with the HIPAA Privacy Rule

I hereby authorize any: medical practitioner, physician, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to LIBERTY BANKERS LIFE INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on LIBERTY BANKERS LIFE INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care, or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that LIBERTY BANKERS LIFE underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

I understand that:

- such information will be used by LIBERTY BANKERS LIFE INSURANCE COMPANY for underwriting and insurability determinations;
- I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
- a picture copy or photocopy of this authorization shall be as valid as the original; and
- any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of LIBERTY BANKERS LIFE INSURANCE COMPANY, P. O. Box 341989, Austin, Texas 78734. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

Proposed Insured (Please print)

Signature of Proposed Insured (or parent if Proposed Insured is under age 16)

Date

Date of Birth

Additional Proposed Insured (Please print)

Signature of Additional Person Proposed for Insurance

Date of Birth

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee, representative, other _____ (Circle one)

LBL-SIM-APP-0408

This Notice Must be Given to Proposed Insured

FAIR CREDIT REPORTING ACT PRE-NOTIFICATION FORM. Thank you for considering Liberty Bankers Life Insurance Company as your insurance carrier. Your application will be processed as quickly as possible. Public Law 91-5088 requires that we advise you that an investigative consumer report may be made in connection with this application which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through personal interviews with friends, neighbors, and associates. You are entitled to be interviewed in connection with an investigative consumer report; and, you have the right to receive a copy of any investigative consumer report by making a written request within a reasonable period of time.

NOTICE TO APPLICANTS FOR INSURANCE. Information regarding your insurability will be treated as confidential. Liberty Bankers Life Insurance Company, or its reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request from you, will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 1-866-692-6901. Liberty Bankers Life Insurance Company, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.

<i>SERFF Tracking Number:</i>	<i>LBLI-125599290</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Liberty Bankers Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>38647</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>New Life Riders & Application</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: LBLI-125599290 State: Arkansas
Filing Company: Liberty Bankers Life Insurance Company State Tracking Number: 38647
Company Tracking Number:
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
Product Name: New Life Riders & Application
Project Name/Number: /

Supporting Document Schedules

Review Status:
Satisfied -Name: Certification/Notice 04/08/2008
Comments:
Attachment:
AR CERTIFICIATION.pdf

Review Status:
Bypassed -Name: Application 04/08/2008
Bypass Reason: New application is being submitted with this filing.
Comments:

Review Status:
Bypassed -Name: Life & Annuity - Acturial Memo 04/08/2008
Bypass Reason: N/A for this filing.
Comments:

Review Status:
Satisfied -Name: Cover Letter 04/08/2008
Comments:
Attachment:
Cover Letter to DOI - AR.pdf

Review Status:
Satisfied -Name: Readability Certification 04/08/2008
Comments:
Attachment:
Readability Certification.pdf

CERTIFICATION

Company Name: **Liberty Bankers Life Insurance Company**

I hereby certify that the forms included in this submission and company procedures meet the requirements of Regulation 19, 49, and AR 23-79-138 as well as all applicable requirements of the Arkansas Insurance Department.

A handwritten signature in cursive script that reads "Chad Leiding".

Chad Leiding
Vice President Compliance

4/8/08

Date

Liberty Bankers Life Insurance Company
1605 LBJ Freeway, Suite 710
Dallas, Texas 75234
(469) 522-4332 / Fax (469) 522-4380

April 9, 2008

Arkansas Insurance Department
Attn: Life and Annuity Forms Filing Department
1200 West Third St.
Little Rock, AR 72201

RE: Liberty Bankers Life Insurance Company
NAIC# 68543 FEIN# 25-1093277
SERFF FILING ID# LBLI-125599290

LBL-WPR-0408	Waiver of Premium Life Rider
LBL-CHILD-0408	Level Term Insurance Children's Rider
LBL-ADD-0408	Accidental Death and Dismemberment Rider
LBL-APP-IWL-0408	Policy Application

To whom it may concern:

The above listed forms are submitted for your review and approval. These forms are new and are not intended to replace any previously approved forms. Our filing fee of \$100 is also included along with a copy of the SERFF Transmittal Header. This fee is based on retaliatory fees based on our state of domicile, Oklahoma.

Riders

- LBL-WPR-0408 is a standard waiver of premium rider where if total disability occurs before the insured's 60th birthday, premiums will be waived while the insured is disabled. The premiums for this rider are listed in the table on the reverse of the rider.
- LBL-CHILD-0408 is a standard convertible level term insurance children's rider. Benefits are payable to age 25. Before the child reaches age 25, the policy may be converted to a permanent life insurance policy without proof of insurability. The Annual premium is \$39.00, the monthly premium is \$3.49.
- LBL-ADD-0408 is a standard accidental death and dismemberment rider with common carrier benefit. The premium is a flat \$1.00 per thousand per year expiring at age 75.

Life riders LBL-WPR-0408, LBL-CHILD-0408, LBL-ADD-0408 will be used with previously approved policy forms LBL-WL-POL-0407-AR, LBL Term20-0607-AR and LBL Term20-RPU-0607-AR.

Policy Application

LBL-SIM-APP-0408 is a new policy application that will be used with previously approved policy form LBL-WL-POL-0407-AR.

To the best of our knowledge, this filing is complete, does not contain any unusual that may differ from industry standards and is intended to comply with the insurance laws of your jurisdiction. Please feel free to contact me as listed below, should you have any questions or need additional information. Your assistance in this matter is greatly appreciated.

Sincerely,

A handwritten signature in cursive script that reads "Chad Leiding".

Chad Leiding, AIRC
Vice President Compliance
Liberty Bankers Life Insurance Company
469-522-4332 (phone)
chad.leiding@libertybankerslife.com

READABILITY CERTIFICATION

COMPANY NAME Liberty Bankers Life Insurance Company NAIC CO# 68543

FORM NUMBER

FLESCH SCORE

LBL-WPR-0408	<u>39.1</u>
LBL-CHILD-0408	<u>60.6</u>
LBL-ADD-0408	<u>53.4</u>
LBL-SIM-APP-0408	<u>* 44.8</u>

scored with policy



Signature of Insurance Company Officer

Vice President Compliance
Typed Name and Title

April 7, 2008
Date

<i>SERFF Tracking Number:</i>	<i>LBLI-125599290</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Liberty Bankers Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>38647</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>New Life Riders & Application</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	LBL-CHILD-0408	04/08/2008	LBL-CHILD-0408 - Child Rider - Generic.pdf
No original date	Form	LBL-APP-IWL-0408	04/08/2008	LBL-SIM-APP-0408-Generic.pdf

CHILDREN'S BENEFIT RIDER
(Level Term Insurance to Age 25, Convertible)
\$5,000 Per Unit
_____ Unit (s)

The Effective Date of this Agreement is the Date of Policy if attached when the Policy was issued. The number of units insured is shown on the Schedule Page. If added later, the Effective Date and number of units of this Agreement are shown above.

The consideration for this Agreement is the application and payment of the Initial Premium. A like sum is payable on each Due Date until this Agreement ends.

We will pay the Sum Insured (units in force) to your Child's Beneficiary immediately after these conditions are met:

1. We receive due proof of the death of an Insured Child.
2. Death occurs while this Agreement is in force for that Child.

SUM INSURED

For each unit of this Agreement:

The Sum Insured on each Insured Child is \$5,000.

DEFINITIONS

Wherever used in this Agreement:

"Insured Child" – means each child of yours (including each stepchild and legally adopted child) who, unless excluded in this Agreement:

1. Is named on the application for this Agreement and has not reached the 18th birthday on the Agreement Effective Date; or
2. Is born to you after the Agreement Effective Date.

Any child you legally adopt after the Agreement Effective Date may be insured by this Agreement without additional charge, after written request to us and subject to our approval. No child will be insured until 15 days old. In no case will the insurance on an Insured Child continue after the next Policy anniversary following the child's 25th birthday.

"Child's Beneficiary" – means you, if living, otherwise your Spouse, if living, otherwise the estate of the deceased Insured Child. You can change this. (See the "Beneficiary" provision of the attached Policy).

"Owner" – (a) During your lifetime, it means the Owner of the Policy; (b) After your death and if your Spouse survives, it means your Spouse; (c) After the death of you both, it means any

surviving Insured Child, but only with respect to the term insurance on his or her life.

PAID UP INSURANCE

In the event of your death while the policy and this rider are in force, any insurance then provided by this rider shall become paid-up term insurance expiring on the life of each insured child on the same date it would have expired had you not died.

CONVERSION PRIVILEGE

1. While this Agreement is in force, the insurance on any Insured Child may be exchanged for a permanent life plan in the same amount. No proof of insurability is needed.
2. At the following special times, the new policy amount may be up to five (5) times the Sum Insured in this Agreement:
 - (a) For conversion effective within 31 days after the next Policy Anniversary following the Insured Child's 25th birthday; or
 - (b) Upon written application to us within 31 days after the date of marriage if prior to the Insured Child's 25th birthday.
- (3) The new policy will be dated with the date of exchange. If so:
 - (a) The new premiums will be based on the classification used in this Agreement for the Child's attained age. The premium will be at the rates then in use by us.
 - (b) Any extra benefits may be added to the new policy only with our consent.
- (4) If this Agreement is in force on a paid-up basis due to your death, the insurance on any person then insured may be converted to any permanent life plan. The new policy amount may not be more than the amount of paid-up insurance. The request must be written and include surrender of that person's paid-up insurance. Premiums will be charged on the new permanent life plan.



Liberty Bankers Life

Insurance Company

Application for "Simplified Issue Market" Use with SIMPL/MWL

P.O. Box 341989 Austin, Texas 78734 1-800-604-8002 FAX 512-263-6981 E-Mail: lblicnb@tslic.com

All information must be provided to avoid delays. All questions are important, please read and complete each question.

Proposed Insured (First Name, Initial, Last Name)

State of Birth _____ Country of Birth _____

Date of Birth _____ Present Age _____

Sex _____ Height _____ Weight _____

Social Security No. _____

Street Address _____

City, State, Zip _____

Home/Cell Phone _____

Work Phone: _____

E-Mail Address _____

Occupation _____

1. Have you used tobacco in any form in the past 12 months?..... ☐ YES ☐ NO
2. Are you a U.S. Citizen, including resident alien? ☐ YES ☐ NO
If No, please explain type of visa or work permit: _____

OWNER of Policy (if other than Proposed Insured)

Relationship _____

Social Security No. _____

Street Address _____

City, State, Zip _____

Home/Cell Phone _____

Plan Applied For: ☐ SIMPL ☐ MWL

☐ OTHER _____

Classification: ☐ Tobacco ☐ Non-Tobacco

Face Amount \$ _____

Premium Amount \$ _____

Amount paid with application \$ _____

Premium Mode:

☐ Monthly Bank Draft

Draft Day: _____

☐ Check here to draft first premium

☐ Monthly List Bill

☐ Bi-Weekly

☐ Payroll Deduction

☐ Quarterly

☐ Semi-Annual

☐ Annual

Primary

Beneficiary _____

Relationship _____

Street Address _____

Home/Cell Phone _____

E-Mail _____

Contingent

Beneficiary _____

Relationship _____

Street Address _____

Home/Cell Phone _____

E-Mail _____

1. Does proposed Insured have existing life insurance policies or annuity contracts?..... ☐ YES ☐ NO
 2. Will this insurance replace or change any other insurance policies or annuity contracts? ☐ YES ☐ NO
- If "YES" to either question, please provide details of the insurance, including Amount, Company & Plan of Insurance and appropriate Replacement Form, if required: _____

Please read each question carefully and answer truthfully before signing application.

If the applicant answers YES to any question in Part 1, DO NOT PROCEED with the application.

Part 1

	YES	NO
To the best of your knowledge and belief, have you:		
1. Ever been diagnosed with congestive heart failure, cystic fibrosis, Alzheimer's, senile dementia, dementia, Down's Syndrome, terminal illness, muscular dystrophy, Huntington's Disease, amyotrophic lateral sclerosis (ALS), or had an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ever been diagnosed or received treatment for AIDS (Acquired Immune Deficiency Syndrome), AIDS Related Complex or tested positive for HIV Virus, or any other disorder of the immune system?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently or within the last 90 days:		
3. Been unable to care for yourself, bedridden at home, confined in a hospital, nursing home, hospice, assisted living or long-term care facility, or using oxygen?	<input type="checkbox"/>	<input type="checkbox"/>
4. Had undiagnosed chest pain, fainting, paralysis, coughed up or vomited blood?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you currently have uncontrolled high blood pressure or uncontrolled diabetes, diabetic coma, insulin shock, or diagnosis of diabetes at age 9 or younger, or diabetes associated with retinopathy, nephropathy, neuropathy or amputation?	<input type="checkbox"/>	<input type="checkbox"/>

If the applicant answers YES to 1 or more questions in Part 2, he/she will be considered for the MWL Plan only.

Part 2

	YES	NO
To the best of your knowledge and belief, within the last 2 years have you 1) had, 2) been diagnosed for, 3) had or have any new symptoms for, or 4) awaiting surgery, medical tests or test results for:		
1. Heart attack, irregular heartbeat, aneurysm, any condition leading to angioplasty or bypass surgery, cardiomyopathy, cardiac defibrillator, heart valve surgery, stroke, cerebrovascular insufficiency or blockage?	<input type="checkbox"/>	<input type="checkbox"/>
2. Internal cancer, melanoma, leukemia, sickle cell anemia, renal insufficiency or failure, hepatitis C, kidney disease (excluding passed kidney stones), liver disease including cirrhosis; chronic pancreatitis, Hodgkin's Disease, lymphoma, chronic lung disease including emphysema?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Paralysis, Parkinson's, Grand Mal epilepsy, multiple sclerosis, lupus or connective tissue disorder, organic brain disorder or suffer from mental retardation?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Schizophrenia, psychosis or suicidal thoughts or attempts, including hospitalization for major depression?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Alcoholism, drug abuse, narcotic addiction, or been convicted of felony?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you currently using a wheelchair or walker on a permanent basis?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Within the last one year, have you had an application for life insurance declined or refused for any reason?	<input type="checkbox"/>	<input type="checkbox"/>

Give Details to Questions Answered "YES" above: (Attach additional sheet, if necessary with applicant's signature) _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Any insurance must first be approved for issuance by Liberty Bankers Life Insurance Company on the basis of this application. Coverage will begin when the policy has been issued, received and accepted by the proposed insured or applicant with the first full premium paid to Liberty Bankers Life Insurance Company, while the proposed insured's health and other conditions remain as described in this application. Liberty Bankers Life Insurance Company is authorized to correct errors and omissions as necessary and acceptance of any policy issued on this application shall constitute ratification thereof, except that any amendment as to amount, classification, plan of insurance or benefits shall be made only with the written consent of the proposed insured or the applicant.

I authorize any physician, medical practitioner, hospital, clinic, other medical medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or employer to give the Company or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself. This authorization also includes information about drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company to release any information obtained only to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. I further acknowledge that I may revoke this authorization at any time by submitting a written request to the Company. As to this Authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for 24 months from the date shown below. I know that I or my representative may request a copy of this authorization.

I certify that I have reviewed the questions and responses contained on this application and that my responses to these questions have been accurately recorded. I understand that no agent is authorized to advise me that any inaccurate answer is acceptable.

X _____ _____ _____
Signature of Proposed Insured Date City/State

Signature of Applicant/Owner (if other than Proposed Insured)	Date	City/ State

Agent Statement:

	YES	NO
1. Did you give the applicant a copy of the Privacy Notice and other disclosure information?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you related to the Proposed Insured?	<input type="checkbox"/>	<input type="checkbox"/>
3. Was this application taken in person?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you know anything not disclosed which might affect the underwriting of this risk?	<input type="checkbox"/>	<input type="checkbox"/>

X _____ Printed Agent's Name	_____ Agent's Signature	_____ Agent's Number
---------------------------------	----------------------------	-------------------------

LBL-SIM-APP-0408

CONDITIONAL RECEIPT – (Cross through if payment is NOT received).

NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO DELIVERY, UNLESS THE FOLLOWING CONDITIONS HAVE BEEN FULFILLED EXACTLY:

INSURANCE ISSUED BASED ON THE APPLICATION WILL TAKE EFFECT ONLY IF THESE CONDITIONS ARE MET:

1. That on the effective date the Proposed Insured is insurable as a standard risk under the Company's rules for the plan amount and premium rate applied for.
2. That the sum paid is equal to the FULL FIRST PREMIUM for the policy applied for.

INSURANCE ISSUED BASED ON THE APPLICATION WILL TAKE EFFECT ON THE LATEST OF:

- (a) date of the application; or (b) date requested in the application; or
(c) date of the last of any medical examinations or tests required under the rules and practices of the Company.

The total amount of insurance which may become effective prior to delivery of the policy to the Owner shall not exceed \$25,000. This amount includes LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS then IN FORCE or APPLIED FOR with this Company.

LIBERTY BANKERS LIFE INSURANCE COMPANY has received \$ _____ for Applicant

By _____ Agent _____ Date _____

**THE PREMIUM CHECK MUST BE MADE PAYABLE TO LIBERTY BANKERS LIFE INSURANCE COMPANY.
DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

This authorization complies with the HIPAA Privacy Rule

I hereby authorize any: medical practitioner, physician, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to LIBERTY BANKERS LIFE INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on LIBERTY BANKERS LIFE INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care, or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that LIBERTY BANKERS LIFE underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations.

I understand that:

- such information will be used by LIBERTY BANKERS LIFE INSURANCE COMPANY for underwriting and insurability determinations;
- I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
- a picture copy or photocopy of this authorization shall be as valid as the original; and
- any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of LIBERTY BANKERS LIFE INSURANCE COMPANY, P. O. Box 341989, Austin, Texas 78734. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

Proposed Insured (Please print)

Signature of Proposed Insured (or parent if Proposed Insured is under age 16)

Date

Date of Birth

Additional Proposed Insured (Please print)

Signature of Additional Person Proposed for Insurance

Date of Birth

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee, representative, other _____ (Circle one)

LBL-SIM-APP-0408

This Notice Must be Given to Proposed Insured

FAIR CREDIT REPORTING ACT PRE-NOTIFICATION FORM. Thank you for considering Liberty Bankers Life Insurance Company as your insurance carrier. Your application will be processed as quickly as possible. Public Law 91-5088 requires that we advise you that an investigative consumer report may be made in connection with this application which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through personal interviews with friends, neighbors, and associates. You are entitled to be interviewed in connection with an investigative consumer report; and, you have the right to receive a copy of any investigative consumer report by making a written request within a reasonable period of time.

NOTICE TO APPLICANTS FOR INSURANCE. Information regarding your insurability will be treated as confidential. Liberty Bankers Life Insurance Company, or its reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request from you, will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 1-866-692-6901. Liberty Bankers Life Insurance Company, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.